CHAPTER 17

A monitoring dilemma: orphans and children made vulnerable by HIV/AIDS

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Introduction

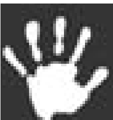
This chapter addresses the situation of children who have been orphaned by AIDS and those who are commonly referred to as having been made vulnerable by the epidemic. As will be evident, indicators for children affected by HIV and AIDS have been mainstreamed throughout the volume. Toward the end of the process of developing the indicators for this project, we took the decision to include a contribution on children orphaned and made vulnerable by HIV and AIDS. This is because considerable attention is being paid both internationally and locally to the development of indicators for so-called orphans and vulnerable children (OVCs). It is *not* our intention to entrench practices which wittingly or otherwise consolidate the category of 'children orphaned by AIDS', thereby contributing to the special treatment of these children at a cost to others who may be as vulnerable and in need of support.

We are concerned about the OVC category in spite of its currency (see also Bray, 2003b). Our contribution seeks to both interrogate the construct and contribute to the debate regarding monitoring systems and indicators for children who are commonly labelled as OVC. We focus on the psychosocial risks and consequences associated with the epidemic, which go beyond narrow health considerations (UNICEF, 2004b, 2005e, 2005b). Chapter 5 in this volume provides indicators for HIV/AIDS that are health- and treatment-related, and will not be repeated here.

The chapter includes a discussion of some of the conceptual challenges and debates relevant to this question and recommends that they remain the subject of ongoing engagement in the development and application of indicators.

Background

Sub-Saharan Africa accounts for only 10 per cent of the world's population. However, 64 per cent of those living with AIDS reside in the sub-continent – 5.5 million of them are South Africans (18.8 per cent of the country's adults). An estimated half of all adults who acquire HIV become infected before they are 25, which emphasises the particularly high rates of infection among children and young people (Eaton et al., 2003).



In examining the psychosocial risks and consequences associated with HIV and AIDS our attention was drawn to a major conceptual challenge that has significant implications for interventions and for monitoring systems. That is, the manner in which we define those children affected by AIDS both for targeting for humanitarian assistance and for monitoring purposes. The definitions of an 'orphan', 'a child made vulnerable by HIV/AIDS', and a 'vulnerable child' need to be clear and precise. While the definition of an orphan in the context of AIDS is unusual (see below), the latter two constructs are particularly problematic.

In the first instance, the problem has its roots in the development of responses to children affected by AIDS.

Initially, and as the death rate due to AIDS rose in Africa, concerns were raised regarding the corresponding rise in orphaned children and the need to address their situation. These children, labelled as 'AIDS orphans', were regarded as highly vulnerable, and were identified for targeted interventions. Of course orphaning will remain an appropriate concern, increasingly so in South Africa as the impact of caregiver death increases its toll on the children who remain behind.

Foster (2006) observes that orphans remain the focus of humanitarian assistance to children affected by HIV/AIDS. However, many children are rendered vulnerable by the epidemic, but are not orphans. Examples include those living with ill carers, and those excluded from school due to stigma, and also as a result of inability to afford fees (as a consequence of loss of income due to illness in the household).

The term 'orphans and vulnerable children' entered the lexicon of the humanitarian aid community and government response as it became evident that the 'orphan' focus was too narrow. This linguistic compromise recognised the need for a broader view, beyond orphaning, of the effects of the epidemic on households and children. While this is a necessary development, the concept is not clear enough to guide the development of a concise and accurate definition of a distinct population of children that can guide efforts to intervene and monitor the situation of the population in question. It is therefore necessary to define the population and identify the manner in which it is distinct.

In the term 'OVC', what is particularly unclear is the meaning of 'vulnerable'. Does this term only encapsulate those 'made vulnerable by HIV and AIDS', and furthermore, what does this mean? Or does it encapsulate children who are vulnerable due to a range of other risks that are not a function of HIV and AIDS?

The second central reason for problems with definitions in this field is related to the hidden nature of HIV and AIDS. As UNICEF (2005b) has noted, we commonly do not know the HIV status of the adults or children (or the causes of death) in most settings in which we want to monitor or intervene. UNICEF's (2005b) response to this problem has been to recommend the use of proxy measures in high-prevalence communities to estimate the number of children who are affected by high adult mortality and morbidity.

The definition below therefore identifies children who have had a parent or an adult household member die or become chronically ill (cause of death is not specified). In contexts with high HIV prevalence, this kind of definition is likely to be a relatively reliable proxy for children affected by HIV and AIDS. According to UNICEF (2005b,

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p. 17), the definition of a child made vulnerable by HIV and AIDS is an individual below the age of 18 who:

i) has lost one or both parents, or
ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or
iii) lives in a household where in the past 12 months at least one adult died and was sick for three of the twelve months before he/she died, or
iv) lives in a household where at least one adult was seriously ill for at least three months in the past twelve months, or
v) lives outside of family care (i.e. lives in an institution or on the streets).

As will be evident, a feature of the AIDS epidemic is the unusual use of the term 'orphan' (see also Monasch & Boerma, 2004). One is prompted to ask why it is that the AIDS epidemic has given rise to a definition in which a child who has lost only one parent is deemed to be an orphan. This is not mere semantics but has consequences for how we count children.

While UNICEF's attempt to address the definition challenge in the case of high-prevalence communities has merit, the potential for inclusion of children made vulnerable by other illnesses and causes of mortality remains. In South Africa, this may serve well for purposive monitoring of high-prevalence communities, but perhaps not for national level monitoring. This is because there is considerable variation in HIV prevalence across communities, and there are many other causes of morbidity and mortality that are not AIDS-related (see chapters 5 and 7). At a national or provincial level, therefore, the UNICEF proxy approach to identifying 'children made vulnerable by HIV and AIDS' may not be appropriate. It risks including too many children who are vulnerable for other reasons, and will distort targeting efforts.

UNICEF (2005b, p. 17) recognises that 'establishing a measurable definition of "vulnerable" is a bigger challenge' than defining orphanhood. We therefore remain challenged by the meaning and operationalisation of the term 'vulnerable' – a construct which could potentially describe a range of populations that require protection (for example very poor children, children on the streets, trafficked children, abused and neglected children, etc.). There are many features of vulnerability (or risk factors) that are common both to children affected by HIV and AIDS and to other groups of vulnerable children, but there are also some features that are particular to children affected by HIV and AIDS. We explore this issue below.

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Vulnerable children: particularities and commonalities

There is emerging consensus that there has been undue focus on children orphaned by AIDS in particular, and that the allocation of services on the basis of this vulnerability is likely to be both inappropriate and inadequate in addressing the needs of children most at risk. Since the situation of children affected by HIV and AIDS is often similar to that of children made vulnerable by poverty, attempts to single out the former group – particularly orphans – from the rest of the population of very vulnerable children are problematic (Loening-Voysey & Wilson, 2001; Save the Children UK, 2003; Richter, Manegold et al., 2004). A review by Save the

Children UK (2003) recognises the complexity of responses to children affected by HIV and AIDS, and recommends that the management of orphanhood should occur within the context of poverty.

It is well recognised that in the South African context, the majority of children are rendered vulnerable by poverty and all its associated challenges to child development and outcomes. Many children, particularly those in poor communities, are also affected by domestic and community violence (see the other chapters in this section). Thus, poverty and violence are two key features of vulnerability which are common to most groups of children requiring protection.

What is clear is that the combined impact of high levels of poverty and living in a community with high HIV prevalence, presents the greatest threats and challenges to children's well-being. This is because children's outcomes are most likely to be detrimentally affected where there are multiple risks to development and functioning, which cumulatively and over time undermine children's well-being; young children are at particular risk (Werner & Smith, 1992; Foster, 2006). Consequently, it is in these multiple-risk communities that the most vulnerable children are likely to reside.

Studies that have attempted to examine the specific contribution of HIV and AIDS have found that they typically serve as an additional stressor in households, families and communities already at risk due to poverty, single parenthood and high levels of exposure to violence (Forsyth et al., 1996; Wild, 2001; Forehand et al., 2002; Brandt, 2005b). These household and environmental features constitute risks to the emotional and psychosocial well-being of caregivers and their children. Consequently, in some domains of functioning, children may exhibit a level of disruption in functioning beyond which the impact of (parental) HIV infection does not result in a marked effect. Further, research has shown that the stage of illness in an infected caregiver, rather than their HIV status per se, places children at risk (Foster, 2006). This is an important point given the fluctuating course of the illness and the fact that wider availability of antiretroviral regimens has the potential to reduce (if not eliminate) the periods of symptomatic illness which have been found to make children most vulnerable.

HIV and AIDS has its most immediate impact on children's home environments. Where the caregiver is ill, she is commonly no longer able to contribute regularly, if at all, towards the economic security of the household, and her capacity to provide emotionally responsive care for her children is challenged (Brandt, 2005a). This increases the vulnerability of all the children, but particularly the very young, especially in contexts within which social support is lacking (Richter, 2003; Brandt, 2005a; Sherr, 2005a, 2005b; Swartz et al., 2005). Older children may be withdrawn from school (or struggle with finding time for school work) as a consequence of having to undertake domestic and subsistence agriculture roles, including seeing to the well-being of sick caregivers (Hunter & Williamson, 2002; Wilson et al., 2002; Bray 2003a, 2003b). Some will be required to seek work to replace the income lost as a consequence of the carer's illness. If the carer dies, this may lead to the children having to move into the care of relatives; heading households if there are no kin to take care of them or their siblings; or losing their homes (if it is appropriated by relatives). Outcomes of children affected by these challenges include reduced child

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survival and health status, compromised safety (through the loss of support and supervision), as well as the risk of maltreatment and neglect. Furthermore, children orphaned or made vulnerable by HIV are at increased risk for emotional and psychological problems, and disrupted attachment relationships which results in difficulties with social interaction (Wilson et al., 2002; Brandt, 2005a). These children are also at risk for reduced guidance, discipline and positive support from adults and peers, which lessens the chances of children developing positive identities and the skills required for participation in the world of work.

HIV/AIDS differs from other chronic illnesses in that there are long periods during which caregivers are asymptomatic, but once manifest, it is associated with particularly painful and debilitating symptoms. However, at this stage in our knowledge, the extent to which the effects on children are different from other chronic illnesses, such as cancer or diabetes, is not clear.

The stigma associated with HIV and AIDS could potentially be a determining factor, differentiating the effects on children who are orphaned or made vulnerable by HIV and AIDS from those affected by other chronic illnesses. Stigma increases the likelihood of social exclusion and isolation (Giese, Meissels et al., 2003).

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Responses to orphanhood

Due to the growing number of children orphaned as a result of parental/caregiver AIDS, residential care has increased in Africa (Williamson, 2005). Results from a study conducted in six African countries show that of the institutions for children orphaned by AIDS included in the study, 35 per cent have been established since 1999 (UNICEF, 2003a). This is despite a vast literature documenting the detrimental effects of institutional care on child development and outcomes (e.g. Sloutsky, 1997; Giese & Dawes, 1999; Zeanah et al., 2003; Williamson, 2005; Browne et al., 2006; Johnson et al., 2006). Among the most significant risks to child well-being associated with residential care is that it reduces children's opportunities to form a stable attachment to a specific adult (Williamson, 2004). The separation or loss of a primary caregiver has repeatedly been linked to emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment (Bowlby, 1984, 1985a, 1985b). In addition, the longer the child remains in residential care, the greater the likelihood that they will suffer significant, long-term difficulties in developing and maintaining relationships with others (Sigal et al., 2003). It is clear that if we seek to improve the outcomes and well-being of children orphaned as a result of parental/caregiver AIDS, institutional care is not the answer and should only be considered as a last resort. Community-based alternatives are not only less likely to involve the violation of children's fundamental rights to survival, protection, development and participation, but also constitute a more effective and cost-efficient response to increasing numbers of children orphaned as a result of parental/caregiver AIDS (Williamson, 2005).

Residential care is costly – the cost per child in residential care is significantly higher than the cost of a child in family care (Williamson, 2005). In fact, the annual cost for one child in institutional care in Tanzania was shown to be ten times that of supporting a child in foster care (Ainsworth & Over, 1997). Consequently,

Williamson cautions against a proliferation of institutions, noting that this response strategy is an inappropriate and expensive approach.

Community-based interventions are more cost-efficient, more likely to meet children's developmental needs, and are less likely to violate their rights.

The policy and legislative environment

Notwithstanding the fact that children affected by AIDS have the same rights to survival, protection and development as enjoyed by other children, they often struggle to realise these rights and acquire access to services they desperately need (Jacobs et al., 2005). Several chapters in this volume cover the range of rights that are applicable to vulnerable children (see chapters 3, 5, 8, 9 and 15 in particular) – these will not be repeated here.

South Africa has a number of policies to address the situation of vulnerable children. The most relevant are the Integrated Management of Childhood Diseases; the National Integrated Plan for Children Infected and Affected by HIV/AIDS; the National Strategic Framework for HIV and AIDS and Sexually Transmitted Infections (STIs) for the period 2000–2005; the Guidelines for the Management of HIV Infected Children 2005; and the Policy Framework for Orphans and Other Children Made Vulnerable by HIV and AIDS 2005 (which outlines the framework for the protection and provision of comprehensive and integrated developmental services for orphans and vulnerable children in six key strategic areas). The Department of Social Development's National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS South Africa 2006–2008 (hereafter the DoSD National Plan) is most relevant to the current discussion.

The Education White Paper and the recently developed Integrated Plan for Early Childhood Development (ECD) in South Africa 2005–2010 (Tshwaragano Le Bana), among others, also address the situation of children affected by HIV/AIDS.

School fee waiver procedures have recently been amended to broaden and facilitate access to free schooling in terms of sections 39(4) and 61 of the South African Schools Act (No. 84 of 1996).[1]

In addition, and most significant, in terms of the Education Laws Amendment Act (No. 24 of 2005), the national Minister of Education is authorised to identify categories of schools that may not charge any school fees. The categories are stratified in terms of the quintiles used to classify schools, with the poorest schools in the first and the best off schools in the fifth quintile. As soon as this system is in place, it will be possible to measure the proportions of children in non-fee-paying schools, as well as those at fee-paying schools who have been exempted from fees (provincial comparisons can be problematic as the quintiles are empirically derived and differ across provinces).

The Integrated Plan for ECD specifically flags the provision of services to children (0–6 years) in families and communities affected by HIV/AIDS.

The DoSD National Plan arises from a set of strategic priorities, and it is evident that systemic supports as discussed above are integral to its formulation. The most relevant strategic priorities are:

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1. Strengthening and supporting the capacity of families to protect and care for OVC; focusing on expanding treatment for infected children and their families; ensuring sustainable food security systems for OVC and their families; ensuring succession planning for each OVC; development of skills training programmes for child-headed households and ensuring that mechanisms are in place to provide psychosocial support to OVC and their families.
2. Mobilising and strengthening community-based responses for the care, support and protection of OVC; placing focus on mobilising and organising for early identification of OVC; developing the capacity of communities to respond to OVC; increasing participation of local authorities in the care and support of OVC; developing co-ordination mechanisms for programmes at community level; identifying and supporting good practice models for the nurture and care of OVC and establishing and maintaining a database of services at a local level.
3. Ensuring that legislation, policy, strategies and programmes are in place to protect the most vulnerable children; placing focus on monitoring, evaluating and aligning policies and legislation; creating and strengthening mechanisms that support delivery of strategies and programmes at all levels; ensuring operational alignment within and among government departments and across all sectors; developing and maintaining a co-ordinated national database that supports the implementation of the policies, strategies and programmes and ensuring that comprehensive curricula and training programmes that support OVC and their families are available.
4. Ensuring access of OVC to essential services; focusing on reviewing current essential services and service delivery mechanisms to determine whether rights of OVC are realised; developing and strengthening programmes that make essential services accessible to OVC and supporting resource mobilization for the implementation of programmes that make essential services accessible to OVC.
5. Raising awareness and advocacy to create supportive environments for OVC; focusing on developing a comprehensive stakeholder communication strategy; creating general awareness of OVC at every level of society and advocating for the rights of the child at every level of society. (2005b, pp. 2–3)

The DoSD National Plan includes a set of programme objectives, activities and associated indicators that are stratified into five domains and which measure:

- Access to treatment for infected children and their primary caregivers, so as to ensure survival of caregivers (and reduce orphaning) as well as prevent transmission of the virus (PMTCT – prevention of mother-to-child transmission) (see also Chapter 5 in this volume);
- Access to food security for children and their families to reduce the risks of mal- and under-nutrition and to ensure positive growth (see also Chapter 5);
- The extent to which succession planning is mainstreamed into intervention programmes for OVC;
- Provision of vocational and skills training programmes to child-headed households to ensure self-sufficiency and to support these vulnerable families;
- Provision of psychosocial support to OVC and their families.

A major difficulty in both the Integrated Plan for ECD and the DoSD National Plan is that *neither* provides an operational definition of a vulnerable child. While they may well be using the UNAIDS and UNICEF definitions (themselves problematic

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with respect to the construct), this is not stated. This is unfortunate as it is likely to lead to confusion among those tasked with targeting and monitoring the population in question. The importance of adopting a standardised, measurable definition of children orphaned and made vulnerable by HIV and AIDS in all countries has been emphasised by UNICEF (2005b), and steps should be taken towards ensuring that this recommendation is fulfilled.

The UNAIDS (2005) strategic approaches to children affected by HIV and AIDS are detailed below. Apart from the country level approaches, they are similar to those developed by South Africa (which has taken the UN approach into account):

- Efforts to strengthen the capacity of vulnerable families;
- Mobilising and strengthening community-based responses to children orphaned and made vulnerable by HIV/AIDS;
- Ensuring access to essential services for orphans and vulnerable children;
- Ensuring that governments protect the most vulnerable children;
- Raising awareness to create a supportive environment for children affected by HIV/AIDS.

An indicator system for children affected by HIV and AIDS should draw on the research literature as well as be aligned with the policies and programmes outlined above. There are four primary reasons. First, alignment permits monitoring of international obligations and policy recommendations. For example, UNAIDS recommends that in all countries, responsibility for national co-ordination of monitoring the situation of adults and children affected by HIV and AIDS, as well as the relevant programme responses, should rest with national AIDS councils. UNAIDS has established a Country Response Information System that seeks to facilitate greater information. National level monitoring indicators 'track the success of the national response as a whole. They give programme managers and decision-makers an idea of whether the sum total of all efforts intended to benefit children orphaned and made vulnerable by HIV and AIDS in a district, region or country are making any difference in terms of slowing the epidemic spread of HIV and reducing its impact on individuals and families' (UNICEF, 2005b, p. 18).

The second reason follows from this point. Alignment enables stakeholders to monitor government's performance in areas that it has identified for response to the epidemic, in line with international and national benchmarks.

Third, various government departments are using (and developing) indicators for this purpose and these should be included in the minimal set used for monitoring purposes. Finally, if one aligns with the state system (at least in relation to core indicators), the data are likely to be more readily available.

The search for good indicators to identify vulnerable children and track interventions for their benefit is far from over. UNICEF (2005b) has produced a set for monitoring national responses to children affected by HIV/AIDS that has ten domains which need to be monitored at the national level (see Appendix 9 in this volume). Some can be accessed via regular surveys and administrative data while others require purpose-made studies, for example, psychosocial support. UNICEF continues a process to refine the psychosocial indicators. Much more needs to be done to identify the best measures and improve their reliability and validity.

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The UNICEF set is necessarily very limited, and does not cover a range of consequences of the epidemic on children, households and communities. Specific studies are required to explore the situation in more depth. It is also important to distinguish between high-level indicators for monitoring the prevalence, situation and services available to children affected by HIV and AIDS, and those needed to monitor the outcomes of particular programmes and policies.

We have identified the major definitional problems with identifying children affected by HIV and AIDS in the UNICEF system. Appendix 9 presents the indicator set they recommend. In the table, the term 'measurement tool' refers to the type of study required in each instance. The term 'orphan' includes all orphaned children, including those whose caregivers have died of causes other than AIDS. As noted above, UNICEF (2005b) uses caregiver mortality as a proxy measure and recommends that it is most appropriate for use in high-prevalence contexts (even though it is intended for national-level reporting). In our view, due to the problems with defining orphans and vulnerable children, it should be used with caution in contexts where prevalence is very uneven across the country and where there is a wide and significant range of other causes of adult morbidity and mortality.

A comprehensive guide to the measures is available in UNICEF (2005b) (which is a set of guidelines in development).

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Recommended indicators

To ensure alignment with international systems, national policies and plans of action our approach to monitoring the well-being of children orphaned and made vulnerable by HIV and AIDS is informed by the UNICEF list. It addresses the main UNAIDS recommendations for national response, speaks to the Save the Children UK (2003) report, and includes indicators relevant to South African policy documents. The full set in Appendix 9 covers the policy goals and domains set by the South African National Plan for OVC released in 2005.

It must be emphasised that despite the conceptual difficulties raised earlier in the chapter, some of which are reflected in the UNICEF list, their approach is recommended in order to be aligned with international practice. Indicators based on locally agreed upon definitions and measures that do not share wider consensus are of limited use.

While we strongly recommend ongoing consideration of the complexities of what is meant by *addressing the needs of orphans and children made vulnerable by HIV and AIDS* (and therefore how we define these groups), in the absence of another more sophisticated standard, the UNICEF approach has many strengths. For one, although it monitors the numbers of orphans and other vulnerable children separately, it does not identify children on the basis of the HIV status of a parent, caregiver or household member and assesses service provision and other needs for the group as a whole.

The measurement tools specified in Appendix 9 should be seen in light of the fact that many countries do not have sound administrative data systems and may not have regular surveys. In South Africa, there are several sources that can provide at

least some of the data needed to obviate the need for expensive national surveys. That said, and given the challenges in obtaining data on the additional indicators in Appendix 9, the focus of regular monitoring should be on the core set.

UNICEF notes that children 'living with or affected by HIV/AIDS, or in countries with high prevalence rates face an extremely high risk of exclusion from access to essential services, care and protection, as parents, teachers, health workers and other basic service providers fall sick' (2005b, p. 16). For this reason, the indicators include measures of service access, such as free schooling, social grants, healthcare and other services. Data from schools (including those in which children are exempted from fees) are available from the Department of Education, and some of the other data are available from the Departments of Health and Social Development.

We suggest that the additional set in Appendix 9 be captured when required for specific purposes, such as the identification of vulnerable children in areas of the country that have high HIV/AIDS prevalence, and where planning for intervention is required.

It is also recommended that the HIV and AIDS vulnerability indicator information is combined with poverty data, as the most vulnerable families are those living with AIDS and in poverty (see the discussion of poverty measurement in Chapter 3 in this volume).

Over and above the set of ten indicators outlined in Appendix 9, we recommend that the following additional domain (adapted from UNICEF and UNAIDS) be monitored as part of the core set:

- HIV knowledge:
  - Comprehensive knowledge of HIV (in 15–24 year olds);
  - Knowledge that condom use can prevent HIV transmission (in 15–24 year olds).

As this chapter was being finalised, recommendations for survey questions to measure the psychosocial well-being of adolescents living in communities affected by AIDS were submitted to UNICEF New York by Snider and colleagues (2006). The document provides a review of recent literature on adolescent psychosocial measures used in African research, as well as survey questions that tap a set of core domains for assessing household, community and personal measures of youth vulnerability, resilience and psychosocial outcomes. The domains are:

- *Caregiver's emotional health-seeking behaviour:* The stability and emotional health of parents is an important determining factor of psychosocial outcomes in children.
- *Caregiver exposure to domestic violence:* Domestic violence is a serious risk to children's psychosocial well-being, and the stability and well-being of caregivers. It is more likely to occur more often in households under severe strain.
- *Use of (harsh) physical punishment or maltreatment in the home:* Use of harsh physical punishment in the home is a serious risk to children's psychosocial well-being and is likely to increase in compromised households.
- *Community maltreatment, exploitation, stigma and discrimination:* Stigma is a known risk to children and households affected by AIDS. It can result in maltreatment and is associated with social exclusion.

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- *Caregiver report of youth's emotional health (and health-seeking behaviour):* Parents tend to under-report children's internalising of emotional problems, while emphasising 'naughty' behaviour (that may also be a sign of emotional distress). However, in any community, the need to consult an authority (medical, faith healer, counsellor or traditional healer) indicates serious concern for children's psychosocial health.
- *Caregiver report on youth's internalising, externalising and risk behaviours:* This domain captures caregivers' assessments of the psychosocial health of youth in key areas (caregiver reports of externalising and risk behaviours are likely to be more accurate than youth self-report; the reverse is true for internalising behaviours).

In the case of domains appropriate for adolescent self-report, the same domains are advised with the addition of measures of the social connectedness or isolation of the child and also exposure to work (work demands on children may increase in the context of AIDS, as noted above).

The recommendations are still to be approved by UNICEF, and must be subject to validation and reliability testing. For this reason they are not included here. The document is available from UNICEF East and Southern Africa in Nairobi and from the first author of this chapter.

The recommended indicators are listed in the table in Chapter 17, Part 2, of this volume. They include policy goals, objectives and measurement parameters, including definitions of the numerator and denominator for each indicator, and possible sources for these data. Prevalence and treatment indicators related to HIV/AIDS are included in Chapter 5.

Finally, due to the similar needs of children who are affected by HIV and AIDS and other vulnerable children (particularly those living in poverty), we recommend that purposive surveys (where administrative data are not readily available or appropriate) be conducted in communities that meet both these criteria. This is where the UNICEF (2005b) system will be of particular assistance.

Note

See Chapter 2 and Part 2 in this volume for an explanation of the five indicator types used for indicator design.

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